FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045427

Facility Name: St. Joseph Home of Chicago

Address: 2650 North Ridgeway (Number) Chicago (City) 60647 (Zip Code)

County: Cook

Telephone Number: (773) 235-8600 **Fax #** (773) 235-2933

IDPA ID Number: 351124441003

Date of Initial License for Current Owners: 06/03/59

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Eliseo Sotelo **Telephone Number:** (773) 235-8600 x 107

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Michael Barth
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	173	Skilled (SNF)	173	63,318	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	173	TOTALS	173	63,318	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,334	48	4,142	6,524	8
9	SNF/PED					9
10	ICF	25,796	13,789		39,585	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,130	13,837	4,142	46,109	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.82%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/03/59

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided _____

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/04 Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	418,856	389		419,245	6,600	425,845		425,845			1
2	Food Purchase		337,928		337,928		337,928		337,928			2
3	Housekeeping	223,038	16,441		239,479		239,479		239,479			3
4	Laundry	103,411	6,302		109,713		109,713		109,713			4
5	Heat and Other Utilities			177,041	177,041		177,041		177,041			5
6	Maintenance	156,228	14,903	47,180	218,311		218,311		218,311			6
7	Other (specify):* Security & waste			84,766	84,766		84,766		84,766			7
8	**TOTAL General Services**	901,533	375,963	308,987	1,586,483	6,600	1,593,083		1,593,083			8
	B. Health Care and Programs											
9	Medical Director					7,200	7,200		7,200			9
10	Nursing and Medical Records	2,944,490	511,889	10,241	3,466,620	1,472	3,468,092		3,468,092			10
10a	Therapy					259,087	259,087		259,087			10a
11	Activities	177,410	5,666	10,888	193,964	578	194,542		194,542			11
12	Social Services	89,405	3		89,408		89,408		89,408			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,211,305	517,558	21,129	3,749,992	268,337	4,018,329		4,018,329			16
	C. General Administration											
17	Administrative	107,231		492,906	600,137		600,137	(157,635)	442,502			17
18	Directors Fees											18
19	Professional Services			299,049	299,049	(274,937)	24,112		24,112			19
20	Dues, Fees, Subscriptions & Promotions			25,053	25,053		25,053	(550)	24,503			20
21	Clerical & General Office Expenses	407,418	19,443	29,719	456,580		456,580		456,580			21
22	Employee Benefits & Payroll Taxes			1,112,703	1,112,703	176,407	1,289,110		1,289,110			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,238	15,238		15,238		15,238			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			302,444	302,444	(176,407)	126,037		126,037			26
27	Other (specify):*											27
28	**TOTAL General Administration**	514,649	19,443	2,277,112	2,811,204	(274,937)	2,536,267	(158,185)	2,378,082			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,627,487	912,964	2,607,228	8,147,679		8,147,679	(158,185)	7,989,494			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St. Joseph Home of Chicago #0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			218,592	218,592		218,592		218,592			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			218,592	218,592		218,592		218,592			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			4,352	4,352		4,352		4,352			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,159	96,159		96,159		96,159			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			100,511	100,511		100,511		100,511			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,627,487	912,964	2,926,331	8,466,782		8,466,782	(158,185)	8,308,597			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	157,635	17-3		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	550	20-7		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 158,185		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 158,185		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St. Joseph Home of Chicago

ID# 0045427

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bad debt expense	$ 157,635	17-3	1
2	Yellow page advertising	550	20-7	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	158,185		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **St. Joseph Home of Chicago** **#** **0045427** **Report Period Beginning:** **07/01/03** **Ending:** **06/30/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**30**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**31**
32	Interest	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**32**
33	Real Estate Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**33**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**34**
35	Rent-Equipment & Vehicles	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**35**
36	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**36**
37	**TOTAL Ownership**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**38**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**39**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**41**
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43**
44	**TOTAL Special Cost Centers**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**45**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Addolorata Villa	Wheeling, IL	FSCSC	Homewood	Religious Mgmt.
		Marian Village	Homer-Glen , IL			
		St. James Manor	Crete ,IL			
		Franciscan Village	Lemont, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-3	Information Technology	$ 138,000	Franciscan Sisters of Chicago Service Corp.		$ 138,000	$	1
2	V	17-3	Administrative, religious srv	175,123	Franciscan Sisters of Chicago Service Corp.		175,123		2
3	V	17-3	Investment mgmt. Fee	9,981	Franciscan Sisters of Chicago Service Corp.		9,981		3
4	V	17-3	Mkt- intercompany expense	10,939	Franciscan Sisters of Chicago Service Corp.		10,939		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 334,043			$ 334,043	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Franciscan Communities Service Corp
Street Address: 1055 w. 175th Street Ste.202
City / State / Zip Code: Homewood IL 60430
Phone Number: (708-647-6500
Fax Number: (708-647-6982

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17-3	Information Technology	% of bed units	2,194	11	$ 1,720,000	$ 1,720,000	173	$ 135,624	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,720,000	$ 1,720,000		$ 135,624	25

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Joseph Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045427

CONTACT PERSON REGARDING THIS REPORT Eliseo Sotelo

TELEPHONE (773) 235-8600 X107 FAX #: (773)235-2933

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 94,171 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	94,171	1928	$ 12,325	1
2	Future site	196,020	2003	290,802	2
3	TOTALS	290,191		$ 303,127	3

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	173		1929	1929	$ 377,812	$		$	$	$ 377,812	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1954	10,227		26			10,227	9
10				1955	5,952		25			5,952	10
11				1956	4,509		24			4,509	11
12				1958	14,846		41			14,846	12
13				1959	17,042		40			17,042	13
14				1963	35,827		20			35,827	14
15				1964	64,840		20			64,840	15
16				1966	59,466		20			59,466	16
17				1967	223,218		20			223,218	17
18				1968	237,183		20			237,183	18
19				1973	182,118		20			182,118	19
20				1974	231,457		20			231,457	20
21				1976	162,056		20			162,056	21
22				1977	1,136,934		20			1,136,934	22
23				1978	470		20			470	23
24				1982	9,434		10			9,434	24
25				1983	1,297,652		20			1,297,652	25
26				1984	409,810		15			409,810	26
27				1985	216,977		20			216,977	27
28				1986	6,710		10			6,710	28
29				1987	15,790		10			15,790	29
30				1988	66,942		20			66,942	30
31				1989	3,134		10			3,134	31
32				1990	273,817	2,916	20	2,916		273,817	32
33				1991	154,978	10,332	15	10,332	0	134,313	33
34	Employee Café/Fire alarm			1992	2,264	151	15	151	0	1,736	34
35	Employee Café/Fire alarm			1992	5,839	292	20	292	0	3,358	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Emergency generator installation	1992	$ 83,803	$ 5,587	15	$ 5,587	$	$ 58,662	37
38	Dumb water repair	1992	2,346		10			2,346	38
39	Hot & cold water pressure tank	1992	35,760	1,788	20	1,788		18,834	39
40		1993	49,024	3,268	15	3,268		34,317	40
41	Completion of trayline	Aug-94	47,708	3,181	15	3,181		30,215	41
42	Credit for trayline	Aug-94	(4,543)	(303)	15	(303)		(2,877)	42
43	Concrete & tuckpointing Nr. North	Sep-94	4,250	425	10	425		4,038	43
44	Install electric trayline	Sep-94	2,475	165	15	165		1,568	44
45		Sep-94	9,027	451	20	451		4,288	45
46	Telephone system equipment	Oct-94	6,499	650	10	650		6,174	46
47	Emergency generator consultation	Jan-95	4,850	323	15	323		3,072	47
48	Chimney repair	Apr-95	618	41	15	41		391	48
49	Chimney repair	Jun-95	120	8	15	8		76	49
50	Masonry repair project	Jun-95	3,300	132	25	132		1,254	50
51	Fire alarm update	Jul-95	2,630	263	10	263		2,236	51
52	Roofing	Jul-95	2,300	92	25	92		782	52
53	Masonry repair project	Oct-95	2,980	119	25	119		1,013	53
54	500 gallon tank system	Nov-95	21,118	845	25	845		7,180	54
55	Networking cabling	Dec-95	3,000	300	10	300		2,550	55
56	New pipes and padding	Dec-95	9,875	395	25	395		3,358	56
57	Entrance canop 3rd floor, deck	Jan-96	9,876	988	10	988		8,395	57
58	Emergency back-up generator	Jan-96	173,754	8,688	20	8,688		73,845	58
59	Temperature controls	Sep-96	1,552	155	10	155		1,164	59
60	Outside of building masonry	Sep-96	41,500	1,660	25	1,660		12,450	60
61	Electrical wirings	Nov-96	789	39	20	39		296	61
62	Outside of building masonry	Dec-96	36,396	2,426	15	2,426		18,198	62
63	Outside of building masonry	Jan-97	44,100	2,940	15	2,940		22,050	63
64	Outside of building masonry	Jan-97	30,420	2,028	15	2,028		15,210	64
65	Outside of building masonry	Jan-97	73,980	4,932	15	4,932		36,990	65
66	Outside of building masonry	Jan-97	59,202	3,947	15	3,947		29,600	66
67	Ward masonry & repairs	Aug-97	100,260	6,684	15	6,684		43,446	67
68	Ward masonry & repairs	Sep-97	70,650	4,710	15	4,710		30,615	68
69	1st foor renovation	Oct-97	9,458	631	15	631		4,098	69
70	TOTAL (lines 4 thru 69)		$ 6,166,381	$ 71,249		$ 71,249	$ 0	$ 5,679,463	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,166,381	$ 71,249		$ 71,249	$ 0	$ 5,679,463	1
2	1st floor renovation	Nov-97	70,229	4,682	15	4,682		30,433	2
3	Wiring & lighting system	Nov-97	3,954	395	10	395		2,570	3
4	Audio cable wall jacks	Nov-97	295	20	15	20		128	4
5	Door hardware & locks	Nov-97	522	35	15	35		226	5
6	Phase I window treatment	Nov-97	10,755	1,075	10	1,075		6,990	6
7	1st floor renovation	Dec-97	75,552	5,037	15	5,037		32,739	7
8	Ward masonry repairs	Dec-97	60,519	4,035	15	4,035		26,225	8
9	2nd floor asbestos removal	Jan-98	5,810	387	15	387		2,518	9
10	Metal & roofing work	Jan-98	12,520	835	15	835		5,425	10
11	Curtains & mini blinds, cafeteria blinds	Feb-98	8,212	411	20	411		2,669	11
12	Electrical wiring & lighting system	Feb-98	12,349	1,235	10	1,235		8,027	12
13	Data cabling	Feb-98	3,919	261	15	261		1,698	13
14	Electrical wiring & lighting system	Feb-98	1,636	164	10	164		1,063	14
15	1st floor painting & floor covering	Mar-98	10,070	671	15	671		4,364	15
16	Install privacy curtains	Mar-98	5,870	293	20	293		1,908	16
17	Door hardware & locks	Mar-98	11,248	750	15	750		4,874	17
18	Install privacy curtains	Apr-98	1,996	100	20	100		649	18
19	1st floor remodeling phase II	Apr-98	92,508	9,251	10	9,251		60,130	19
20	Signage phase I & II	Apr-98	1,203	80	15	80		521	20
21	Telephone update	Apr-98	227	15	15	15		98	21
22	Lighting fixtures	Apr-98	146	15	10	15		95	22
23	Masonry repairs	May-98	71,682	4,779	15	4,779		31,062	23
24	Phase II window treatment	May-98	3,598	360	10	360		2,338	24
25	1st floor remodeling phase II	May-98	90,688	6,046	15	6,046		39,298	25
26	Remove asbestos tiles	Jun-98	13,056	870	15	870		5,658	26
27	Install privacy curtains for residents	Jun-98	5,376	269	20	269		1,747	27
28	Signage	Jun-98	2,856	190	15	190		1,238	28
29	Install privacy curtains for residents	Jul-98	2,508	125	20	125		690	29
30	Install fence	Jul-98	2,055	137	15	137		754	30
31	Signage	Jul-98	1,390	93	15	93		510	31
32	Lighting system	Aug-98	526	53	10	53		289	32
33	Flame retardant window treatment	Sep-98	5,531	553	10	553		3,042	33
34	TOTAL (lines 1 thru 33)		$ 6,755,187	$ 114,471		$ 114,471	$ 0	$ 5,959,439	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,755,187	$ 114,471		$ 114,471	$ 0	$ 5,959,439	1
2	1st floor remodeling	Sep-98	61,819	4,121	15	4,121		22,667	2
3	Electrical wiring & lighting	Oct-98	14,806	1,481	10	1,481		8,143	3
4	Ductwork modifications	Nov-98	3,228	323	10	323		1,775	4
5	Fireproof elevator, Mec Rm. Gen. &Boiler	Dec-98	5,800	580	10	580		3,190	5
6	New water treatment	Dec-98	3,792	379	10	379		2,086	6
7	Pull switch & night lights	Jan-99	10,735	1,074	10	1,074		5,904	7
8	Sewage pump	Jan-99	3,242	324	10	324		1,783	8
9	Replace convent roof	Feb-99	20,000	2,000	10	2,000		11,000	9
10	Lighting fixtures	Mar-99	354	35	10	35		195	10
11	Roof repairs	Mar-99	5,450	545	10	545		2,998	11
12	Sump pump	Mar-99	1,466	147	10	147		806	12
13	Door fire alarm	Apr-99	6,676	668	10	668		3,672	13
14	Garbage compactor	Jul-99	6,337	634	10	634		2,852	14
15	Fire protection survey	Aug-99	900	90	10	90		405	15
16	Magnetic door holders	Oct-99	2,100	210	10	210		945	16
17	Boiler repair	Dec-99	1,432	143	10	143		644	17
18	Replace 2nd & 3rd floor windows	Jan-00	4,700	470	10	470		2,115	18
19	Drapes and blinds	Mar-00	19,066	1,907	10	1,907		8,580	19
20	Replace 2nd & 3rd floor windows	May-00	9,463	946	10	946		4,258	20
21	Replace 2nd & 3rd floor windows	Jun-00	9,443	944	10	944		4,249	21
22	Install wrought iron fence	Aug-00	4,737	316	15	316		1,105	22
23	Install plumbing for 3 tubs	Dec-00	5,200	347	15	347		1,213	23
24	Paint job for 2nd and 3rd floors	Dec-00	3,807	761	5	761		2,665	24
25	Install awnings	Mar-01	3,000	200	15	200		700	25
26	Install chain link fence	May-01	1,831	122	15	122		427	26
27	Install awnings	Jun-01	4,600	307	15	307		1,073	27
28	Paint job for hallways	Jun-01	634	127	5	127		444	28
29	Paving	Jan-72	7,555		8			7,555	29
30	Sidewalks	Jan-74	2,834		15			2,834	30
31	Repaving	Jan-75	3,640		8			3,640	31
32	Blacktop	Jan-79	9,700		8			9,700	32
33	Gate entrance	Jan-86	986		3			986	33
34	TOTAL (lines 1 thru 33)		$ 6,994,520	$ 133,672		$ 133,672	$ 0	$ 6,080,049	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,994,520	$ 133,672		$ 133,672	$ 0	$ 6,080,049	1
2	Tarring & sealcoating	Jan-86	679		8			679	2
3	Concrete	Jan-88	15,525	776	20	776		10,000	3
4	Landscaping	Jan-88	749	75	10	75		225	4
5	Trinity rodding service	Dec-95	9,876	658	15	658		1,975	5
6	Ward contracting	Jan-96	2,980	199	15	199		596	6
7	Land improvement	Jul-97	12,325	822	15	822		2,465	7
8	Sadewalk	Jan-99	4,285	286	15	286		857	8
9	Paint job for hallways	Jul-01	2,393	479	5	479		1,196	9
10	Prog. Digitial access control	Aug-01	1,593	159	10	159		398	10
11	Install hot water mix valve	Aug-01	1,305	131	10	131		326	11
12	Install alarm system	Sep-02	5,325	533	10	533		1,331	12
13	Refurbish employee cafeteria	Oct-02	7,976	532	15	532		1,329	13
14	Bldng tuckpointing	Feb-02	3,600	360	10	360		900	14
15	Gas valve for #2 boiler	Mar-02	2,860	191	15	191		477	15
16	Smokestack demolition	Apr-02	45,420	2,271	20	2,271		5,678	16
17	Rebuilt chiller	Aug-02	4,103	274	15	274		410	17
18	Install cantilever gates	Sep-02	325	108	3	108		163	18
19	Demolish balcony N. bldg.	Sep-02	12,974	865	15	865		1,297	19
20	Install awnings N. Bldg door	Sep-02	1,200	80	15	80		120	20
21	Smokestack removal	Nov-02	4,450	223	20	223		334	21
22	Smokestack removal	Dec-02	2,250	113	20	113		169	22
23	Smokestack removal	Jan-03	2,250	113	20	113		169	23
24	Refurbish admitting office wallcovering	Apr-03	684	137	5	137		205	24
25	Signage (downpayment)	Jun-03	350	35	10	35		53	25
26	Install roofing	Jun-03	1,250	125	10	125		188	26
27	Install signage	Aug-03	990	50	10	50		50	27
28	Install airconditioning units	Sep-03	1,404	140	5	140		140	28
29	Relocate sprinkler system	Dec-03	500	10	25	10		10	29
30	Combustion test for boiler 1 & 2	Jan-04	650	22	15	22		22	30
31	Install CO detector for boiler	Jan-04	429	14	15	14		14	31
32	Emergency service generator	Jan-04	662	28	12	28		28	32
33	Clean burners & heat exchangers	Jan-04	320	11	15	11		11	33
34	TOTAL (lines 1 thru 33)		$ 7,146,203	$ 143,489		$ 143,490	$ 0	$ 6,111,862	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 7,146,203	$ 143,489		$ 143,490	$ 0	$ 6,111,862	1
2	Combustion test for boilers 1 & 2	Jan-04	605	20	15	20		20	2
3	Install new radiator for generator	Feb-04	2,611	87	15	87		87	3
4	Repair south elevator cables	Mar-04	14,000	350	20	350		350	4
5	Install motor starter for boiler	Mar-04	1,692	56	15	56		56	5
6	Replace water heater	Mar-04	5,237	262	10	262		262	6
7	South elevator load test	May-04	2,500	63	20	63		63	7
8	Belts and batteries for generators	Jun-04	1,219	51	12	51		51	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,174,066	$ 144,378		$ 144,378	$ 0	$ 6,112,751	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,080,658	$ 68,214	$ 68,214	$		$ 716,634	71
72	Current Year Purchases	20,369	5,542	5,542			5,542	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,101,027	$ 73,756	$ 73,756	$		$ 722,176	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van-Dodge Ram	1997	Nov-03	$ 3,700	$ 463	$ 463	$	4	$ 463	76
77										77
78										78
79										79
80	TOTALS			$ 3,700	$ 463	$ 463	$		$ 463	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,581,920	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 218,596	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 218,596	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,835,389	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Architect, construction.	$ 2,207,803	92
93			93
94			94
95		$ 2,207,803	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 534,394	$	1
2	Cash-Patient Deposits	51,428		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	193,715		3
4	Supply Inventory (priced at)	38,370		4
5	Short-Term Investments			5
6	Prepaid Insurance	73,463		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(708,175)		8
9	Other(specify): Cash surrender Value	122,281		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 305,476	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	290,802		13
14	Buildings, at Historical Cost	7,174,065		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,104,726		16
17	Accumulated Depreciation (book methods)	(6,835,389)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	2,207,803		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,942,007	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,247,483	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 769,848	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,840		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	552,282		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to third parties	10,000		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,403,970	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,403,970	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,843,513	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,247,483	$	48

***(See instructions.)**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,869,486	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,869,486	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,762,608)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,100	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Unrealized gain and losses**	18,940	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,740,568)	17
	B. Transfers (Itemize):		
18	**Fund transfer-FSCSC**	650,000	18
19	**Fund transfer- FC communities**	59,351	19
20	**Fund transfer- FC Holding**	(1,994,756)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,285,405)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,843,513	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,137,506	1
2	Discounts and Allowances for all Levels	(1,721,133)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,416,373	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,500	12
13	Barber and Beauty Care	6,429	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	27,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 34,929	23
	D. Non-Operating Revenue		
24	Contributions	10,509	24
25	Interest and Other Investment Income***	219,367	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 229,876	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Chapel revenue mass stipends	5,474	28
28a	COBRA & misc items	17,523	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,997	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,704,175	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,593,083	31
32	Health Care	4,018,329	32
33	General Administration	2,536,268	33
	B. Capital Expense		
34	Ownership	218,592	34
	C. Ancillary Expense		
35	Special Cost Centers	4,352	35
36	Provider Participation Fee	96,159	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,466,783	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,762,608)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,762,608)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,648	2,120	$ 76,777	$ 36.22	1
2	Assistant Director of Nursing	1,764	2,080	66,291	31.87	2
3	Registered Nurses	30,679	34,654	874,842	25.25	3
4	Licensed Practical Nurses	23,274	26,404	530,382	20.09	4
5	Nurse Aides & Orderlies	105,213	116,243	1,213,677	10.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,579	5,237	102,885	19.65	8
9	Activity Director	1,858	2,112	36,420	17.24	9
10	Activity Assistants	11,102	12,611	140,990	11.18	10
11	Social Service Workers	3,676	4,152	89,405	21.53	11
12	Dietician	1,792	2,120	50,563	23.85	12
13	Food Service Supervisor					13
14	Head Cook	1,773	1,957	27,525	14.06	14
15	Cook Helpers/Assistants	30,393	33,692	340,768	10.11	15
16	Dishwashers					16
17	Maintenance Workers	5,083	5,614	86,296	15.37	17
18	Housekeepers	20,506	23,018	223,038	9.69	18
19	Laundry	8,964	10,295	103,411	10.04	19
20	Administrator	1,780	2,120	107,231	50.58	20
21	Assistant Administrator					21
22	Other Administrative	8,183	9,326	261,510	28.04	22
23	Office Manager					23
24	Clerical	12,885	14,182	215,840	15.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,853	2,113	25,233	11.94	31
32	Other Health C: ward secretary	1,662	1,966	28,020	14.25	32
33	Other(specify) central supply	1,858	2,058	26,383	12.82	33
34	TOTAL (lines 1 - 33)	280,525	314,074	$ 4,627,487 *	$ 14.73	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	165	$ 6,600	1-5	35
36	Medical Director	132	7,200	9-5	36
37	Medical Records Consultant	32	1,472	10-5	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,754	137,741	10a-5	40
41	Occupational Therapy Consultant	1,631	119,259	10a-5	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	17	2,087	10a-5	43
44	Activity Consultant	15	578	11-5	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,746	$ 274,937		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Richard Bracken	Administrator		$ 107,231
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,231

B. Administrative - Other

Description	Amount
	$ 481,967
TOTAL (agree to Schedule V, line 17, col. 3)	$ 481,967
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Dr. Salazar	Medical Director	$ 7,200
Carlin Associates	Nursing Consultant	1,472
Karen Hemzacek	Dietary consultant	6,600
Quality Care Consultants	Activity consultants	578
Alliance Rehab	Physical therapy	137,741
Alliance Rehab	Occupational therapy	119,259
Alliance Rehab	Speech therapy	2,087
Sosin & Lawler	Legal Fees	3,132
FR & R	Medicare cost report	1,400
Ernst & Young	Audit	4,977
Daniel Edelman	Bond consultant	2,093
Pro Business	Payroll preparation	12,510
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 299,049

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 176,407
Unemployment Compensation Insurance	30,364
FICA Taxes	353,033
Employee Health Insurance	461,694
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental & Vision	63,763
Retirement benefits 401 K match	84,935
Life Insurance	29,929
Tuition reimbursement	1,123
PTO liability	56,302
Employee Lab screening	1,990
Employee Benefits-other	29,570
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,289,110

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,451
Advertising: Employee Recruitment	7,156
Health Care Worker Background Check	961
(Indicate # of checks performed 38)	
Dues, fees & subscription	10,401
Advertising	5,085
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(550)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,504

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,173
In-State Travel	5,431
Seminar Expense	8,635
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,239

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St. Joseph Home of Chicago # 0045427 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN-6,484 AAHSA-96**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **68,005** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **96,159**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **ERNST & YOUNG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT YET AVAILABLE.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

St Joseph Home of Chicago
Schedule V (Line 7-3)
June 30, 2004

Description	G/L Acct.	Amount
Security Service	80140-553	68,532
Pest Control	80150-555	2,358
Trash Removal	80150-556	13,876
Total		**84,766**

St Joseph Home of Chicago
ScheduleXVII Other Revenue-(Line 28 & 28a)
June 30, 2004

Line 28-Chapel Revenue	**G/L Acct.**	**Amount**
Mass stipends and mass donations	45100-053	**5,474**

Line 28a- Misc. Revenue & COBRA

COBRA payment	45100-065	11,327
Rummage sale	45100-060	3,442
Linda Bolin repayment	45100-060	763
Guest meal	45100-060	113
Polling place income	45100-060	200
Sale of Piano & furniture	45100-060	350
Gaits, belts pads, copies and uniforms	45100-060	456
Raffle sale	45100-060	281
Refunds, and late fee charge	45100-060	624
Discount	45100-064	23
Misc.Cash adjustment	45100-060	(57)
Total		**17,523**

St Joseph Home of Chicago
ScheduleXVII Non-Operating Revenue (Line 25)
June 30, 2004

Line 25- Interest & Investment Income

Interest Income	45700-001	12
Interest Income	45100-061	204
Interest Income	45700-005	32,952
Dividend Income	45700-025	14,457
Dividend Income	45700-041	20,373
Gain on sale of investment	45700-061	76,492
Gain on sale of investment	45700-065	74,876
Total		**219,367**

Note: There was no interest expense included in this cost report.

St Joseph Home of Chicago
ScheduleVIII B.Consultant Services
June 30, 2004

Description	G/L Acct.	Amount
Carlin Associates- medical records	60900-614	1,472
Karen Hemzacek-dietary consultant	80040-674	6,600
Dr. Mario Salazar- medical director	80050-510	7,200
Alliance Rehab-physical therapy srvc	70500-502	137,741
Alliance Rehab-occupational therapy srvc	70500-503	119,259
Alliance Rehab-speech therapy srvc	70500-504	2,087
Quality Care Consultants- activity	80020-519	578
Total		**274,937**

St Joseph Home of Chicago
ScheduleXIX -B.Administrative -Other
June 30, 2004

Description	G/L Acct.	Amount	
Mgmt fee-investment	80050-651	9,981	
FSCSC- admin religious	80050-675	175,123	
FSCSC- Information technology	80050-690	138,000	
KRONOS-Time clock	80070-540	667	
A/R Medicare billing fee	80070-629	562	
Marketing -intercompany expense	80080-684	10,939	
Bad Debt Expense	92250-830	171,992	
Bad debt recoveries	92250-840	(14,357)	157,635 Schedule V, line 17-7 also VI,line 24
Total		**492,906**	Schedule V, line 17-3

St Joseph Home of Chicago
ScheduleXIX -C.Professional Services
June 30, 2004

Description	G/L Acct.	Amount
Carlin Associates- medical records	60900-614	1,472
Karen Hemzacek-dietary consultant	80040-674	6,600
Dr. Mario Salazar- medical director	80050-510	7,200
Alliance Rehab-physical therapy srvc	70500-502	137,741
Alliance Rehab-occupational therapy srvc	70500-503	119,259
Alliance Rehab-speech therapy srvc	70500-504	2,087
Quality Care Consultants- activity	80020-519	578
Sosin & Lawler- legal fees	80050-604	3,132
FR & R- cost report consulting	80050-610	1,400
Daniel Edelman- financial consultant	80050-610	2,093
Ernst & Young- Audit	80070-621	4,977
Pro Business- payroll preparation	80070-570	12,510
Total		**299,049**

Legal Fees - Sosin & Lawler	Invoice #	
	31803	306
	32744	294
	32745	1,148
	33633	535
	34081	315
	34538	282
	34539	216
	35449	38
	Total	**3,132**

St Joseph Home of Chicago
ScheduleXIX D. Employee Benefits and Payroll Taxes
June 30, 2004

Description	G/L Acct.	Amount
Worker's Compensation	92000-755	176,407
PTO Liability	93000-102	56,302
FICA	93000-201	353,033
Group Health	93000-203	461,694
Group Dental	93000-204	51,314
Group Vision	93000-205	12,449
Retirement benefits	93000-207	84,935
Life Insurance	93000-208	29,929
Unemployment compensation	93000-209	30,364
Tuition reimbursement	93000-210	1,122
Other employee benefits	93000-211	29,570
Employee lab screening	93000-213	1,990
	Total	**1,289,110**

St Joseph Home of Chicago
ScheduleXIX F. Dues , Fees Subscriptions & Promotions.
June 30, 2004

Description	G/L Acct.	Amount	
IDPH license fee	80050-707	1,451	
Advertising:Employee Recruitment	80100-648	7,156	
Background check (# ckd._____	80050-612	961	
Dues and Subscription:			
Fd-dues & subscription	80040-430	225	
Nur-dues	60900-430	1,182	
Nur- books/reports	60900-431	68	
Act-dues	80020-430	80	
PC-dues	80110-430	146	
Soc-dues	80030-430	50	
Adm-dues	80050-430	8,364	
Adm-books/reports	80050-431	126	
HR dues	80100-430	160	10,401
Advertising & promotion	80080-645	4,408	
Advertising & promotion	80080-646	127	
Advertising yellow pages	80080-647	550	5,085
	Sub Total	**25,053**	
Less: Yellow page advertising		(550)	
	Total	**24,503**	

St Joseph Home of Chicago
ScheduleXIX G. Travel & Seminar
June 30, 2004

Description	G/L Acct.	Amount	
A. Out of State Travel			
Adm- mileage of of town	80050-435	1,173	
B. In State Travel			
	80040-436	134	
	80140-436	1,475	
	69000-436	881	
	80110-436	343	
	80030-436	53	
	80130-436	279	
	80050-436	1,082	
	80070-436	513	
	80080-436	262	
	80100-436	408	5,431
C. Seminar Expense			
	80040-434	348	
	60900-434	3,878	
	69000-434	908	
	80020-434	77	
	80110-434	60	
	80030-434	157	
	80050-434	3,042	
	80080-433	117	
	80140-434	50	8,635
	Total	**15,238**	